Reading Romanow

The Implications of the Final Report of The Commission on the Future of Health Care in Canada for Women

by

The National Coordinating Group on Health Care Reform and Women

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with

Olena Hankivsky, Beth Jackson and Marina Morrow

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Preface

This paper offers a chapter-by-chapter gendered analysis of the Final Report of the Royal Commission on the Future of Health Care, *Building on Values: The Future of Health Care in Canada* (Romanow 2002). This gendered analysis of the Romanow Report demonstrates some of the consequences of the Report's failure to take women fully into account.

This analysis was prepared by the National Coordinating Group on Health Care Reform and Women whose members are: Pat Armstrong (Chair of the Coordinating Group and York University), Madeline Boscoe (Canadian Women's Health Network), Barbara Clow (Atlantic Centre of Excellence for Women's Health), Karen Grant (University of Manitoba and National Network on Environments and Women's Health), Ann Pederson (British Columbia Centre of Excellence for Women's Health), and Kay Willson (Prairie Women's Health Centre of Excellence). In addition, Olena Hankivsky (Simon Fraser University), Beth Jackson (York University), and Marina Morrow (University of British Columbia and British Columbia Centre of Excellence for Women's Health) joined the Coordinating Group for the purpose of lending their expertise to the development of this analysis.

The National Coordinating Group came together in 1998 as a collaborative group of the Centres of Excellence for Women's Health, and the Canadian Women's Health Network, with advice and financial support from the Women's Health Bureau. The Group's mandate is to investigate the impact of health care reform on women as providers, decision makers and users of the health care system. We aim to increase awareness and understanding of the impact of health care reform on women and wish to become involved in the promotion of such activities.

The Group met on the day the Report was released to do a collective assessment of the Report in terms of its impact on women. On the basis of this shared work, individuals drafted detailed analyses of specific chapters. Olena Hankivsky prepared the analysis of Chapter 2 of the Report, Beth Jackson prepared the analysis of Chapter 6 of the Report, and Marina Morrow prepared the analysis of Chapter 11 of the Report. The remainder of the document was prepared by the members of the Coordinating Group, as was the final draft of this document.

We wish to thank Jane Springer for her editorial assistance.

Introduction

The process of developing the Final Report for the Commission on the Future of Health Care in Canada was a valuable one for women. The steps leading to *Building on Values: The Future of Health Care in Canada,* Final Report of the Commission on the Future of Health Care in Canada (hereafter referred to as the Report), allowed many Canadian women to voice their concerns and set out their visions for a health care system that works for them. The process is an important example of how to consult Canadians while ensuring that policy choices are examined in the context of available research. The research produced for the Commission constitutes a rich and accessible resource that will continue to provide a basis for planning for care.

In its introduction, "A Message to Canadians," the Report confirms the central values that Canadians said must remain as the foundation for our health care strategies. In rejecting a system "where money, rather than need, determines who gets care" (Romanow 2002: xx), the Report promotes a health care system for all women, and in calling for stable and predictable funding, it confirms priorities that matter for women.

The careful examination of user fees, medical saving accounts, de-listing of services, greater privatization and a parallel private system is welcome. The rejection of these strategies on the basis of evidence is particularly critical for women, given that women constitute the primary labour force in health care. The acknowledgment that "the health care system depends on people" (Romanow 2002: 105) is an essential starting point for care planning, as women know well. Women are also the majority of those receiving care and most of those least able to afford care that is based on ability to pay or least able to access care that is based on full-time paid work (Armstrong et al. 2002).

The recognition of diversity is also critical for women. Women understand the need to reject "a one-size fits-all approach to health care delivery" (Romanow 2002: xviii), while maintaining a common approach based on core values. A comprehensive and accountable system would help all women. It would also reduce differences among them in terms of access to care and their provision of care.

A renewed emphasis on primary care, disease prevention, health promotion and access for those outside urban areas is equally important for women. Home care too is of particular interest, and a firmer footing for such care in the public system would improve women"s conditions for health and care. Women would benefit as well from a more cautious approach to trade agreements and protections for a non-profit, Canadian approach to care.

However, the Report is fundamentally flawed. By not offering a gendered analysis, it fails to consider women's places in the health care system and the consequences of health care reforms for women in different locations throughout the system. The issue is not whether the Report is responsive to yet another "special interest group," but that planning that fails to take women into account is fundamentally flawed. Health Canada recognizes gender, sex and culture as three of 12 determinants of health precisely because they are critical components in the structuring and

impact of the system.[1] All populations are gendered and in all populations, gender interacts with culture and racialized categories, as well as with economic and other locations, to shape both participation in and the consequences of health care.

The United Nations Development Program (UNDP) *Human Development Report 1999* makes clear that policies that are not engendered are endangered, and concludes that "families, nations and corporations have been free-riding on caring labour, provided mostly by women, unpaid or underpaid" (UNDP 1999: 7). Failing to consider the pervasive implications of gender means failing to develop strategies that will be effective now or in the long run, effective not only for women but for men. Such evidence has led Canada to require a gender-based analysis of all policy -- an analysis that is absent from the Romanow Report.

Why is health reform a women's issue? There are at least six reasons.

First, care work is women's work. Women account for over 80% of those providing paid care and a similar proportion of those providing direct personal care as unpaid providers (Morris 2002). Reforms over the last decade have meant there are fewer hours of paid work for providers who have been formally taught the required skills and more hours of unpaid work for those without formal training. The care work in the formal system cannot be understood without recognizing that it is women who do this work and that women's care is integrally linked to their unpaid caregiving. The Report fails to acknowledge -- much less address -- the full range of gendered care work.

While there is much discussion about how people prefer to be cared for at home, there is little about the preferences of those who must provide the care. Six years before the Romanow Commission, Prime Minister Chrétien appointed the National Forum on Health to make recommendations on the future of health care. Women told that group that they did not want to be "conscripted" into care work (National Forum on Health 1997:19). But this invisible conscription has only increased, as more people are sent home quicker and sicker and fewer are allowed admission into public institutions or publicly paid home care.

Although this is often described as "sending care back home," women are taking on tasks and responsibilities their grandmothers never dreamed about. They insert catheters and apply oxygen masks, handle breathing tubes and IVs. Women giving and receiving care are often subject to violence and other risks, especially when the care is provided in isolated households. Without support or training, women providing unpaid care often end up in poor health themselves and may provide poor care. Many women want to care and are rewarded by caregiving. However, inadequate resources and lack of choice limit these rewards while making the caregiving more difficult.

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[1]The 12 determinants of health are: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices, health child development, biology and genetic endowment, health services, gender and culture (Health Canada 1999).

The Report acknowledges that women do most of the home care and often risk their health in the process. However the failure to consider chronic care and care for those with disabilities leaves out of the Report much of the most long-term and stressful women's work. Equally important, by offering relief in terms of Employment Insurance, the Report ignores the fact that many women who provide care are not eligible for benefits under this program precisely because their unpaid care works makes it impossible to take on enough paid work.

The application of business practices to health services, combined with cutbacks, have at the same time contributed to deteriorating conditions for those who still have paid jobs. Women employed to provide care are pushed to work harder and faster, with less control over the care they provide. Increasingly, the women who cook, clean, do laundry and serve food are defined as providing hotel services rather than care services, even though the women know they are care workers, and food, environments and hygiene determine health. The Report defines the work they do as ancillary services, ignoring both the evidence of their critical role in health care and the skills they bring to the work.

The results of the new business strategies are the highest injury rate of any industry, the highest rate of casual employment and low rates of job satisfaction (Canadian Institute for Health Information 2001). In other words, their work in health is making women sick. The Report acknowledges the deteriorating working conditions for those it defines as care providers, but fails to link these deteriorating conditions to for-profit business practices or to the gender of the work force. And it ignores entirely the health of the women who make up the majority of those providing care. Moreover, it offers no concrete recommendations on how to address the work organization problems that are recognized.

Second, women are the majority of those requiring health care services. As the majority of the population and all of those giving birth, it is women who use care more. And women are the overwhelming majority of the elderly who are poor and need care. As well, women account for up to three-quarters of the institutionalized elderly. The failure to consider long-term care either in facilities or at home has particularly negative consequences for women. Moreover, women are more likely than men to have their care needs go unmet. It is also women who take children for care and who take responsibility for children's health. Yet this dimension of care access is not considered in the Report, even though healthy child development is recognized by Health Canada as a determinant of health.

Third, women have fewer financial resources than men to assist them in getting or giving care. They are less likely than men to have health coverage through their paid job and more likely than men to be poor. This is particularly the case for women past retirement age, most of whom do not have pensions from their paid work (Statistics Canada 2000). Thus when public care is not available or fees are charged, women find it more difficult than men to purchase care for themselves, their children or their other dependent relations. It is therefore women who will suffer most from the failure of the Report to recommend that public funding go only to non-profit services and to prohibit a parallel private system.

Fourth, in spite of the fact that almost all health care is provided by women and women are most

of those who receive care, women are a minority of those making policy decisions about health care. They have few means of influencing how major policy decisions are made, even though their daily practices bring so many of them into direct contact with the health care system. The lack of an enforcement mechanism in the Report leaves women with little influence on the system and few means of ensuring care will be there.

Fifth, the emphasis on evidence in the provision of services may also have a negative impact on women because women are less likely than men to be the subjects in developing evidence (Grant 2002). The managerial approach discussed in the Report, which emphasizes the need for more data as the basis for decision-making, fails to recognize the values set out at the beginning of the Report. Nor does it recognize the gendered ways data are constructed and the ways they tend to ignore diversity. This emphasis on data also fails to take into account the impact of such approaches on those who give and receive care.

Sixth, cutbacks that increase the reliance on purchased care and reforms that fail to accommodate differences increase inequality among women. First Nations, Inuit and Métis women face persistent and pervasive obstacles in giving and receiving care. Like women from immigrant, refugee and visible minority communities, they often face racism, along with language and cultural barriers. And poor women find it harder not only to stay healthy and care for their children, but also to get the care they need. There is some recognition of these different needs in the Report, and this is clearly a step in the right direction. However, gender is seen as one of many variables rather than one that intersects with these others to create even greater vulnerabilities in terms of care receiving and caregiving.

Women are facing deteriorating conditions for giving and receiving care, as the Report documents. However, the full implications of these conditions are often hidden by women's efforts to make up for the gaps and the negative consequences of system reforms, camouflaging just how far reforms have gone in cutting care. Indeed, women are expected to fill these gaps. They feel responsible and are held responsible for care. Only a gendered analysis can reveal the forces at work in creating these conditions.

Although they are a minority at senior policy levels, women have been prominent among those demonstrating the need for a determinants of health approach. Such an approach would address the structures, conditions and pressures that create and perpetuate the inequalities that are critical to health and care. While the Report mentions well-being and the social determinants of health, the approach remains fundamentally biomedical. It focuses primarily on the interventions central to a medical understanding of health. The move beyond doctors and hospitals that is promised in the Report's Executive Summary extends to only a few more health professionals, a few more drugs and a little home care. All of these are defined in terms of acute care or of providing relief to that system. Determinants of health in and outside the health care system are largely ignored, including gender.

These are some of the major issues raised by the fact that the Report does not take a gendered approach to health care reform. In the remainder of this document, we provide a detailed analysis of the issues and commentary on the recommendations of the Report.

Throughout the Report, the question is asked "What Does This Mean for Canadians?" Through this analysis and commentary, we challenge policy makers to think also about "what this means for women."

Chapter 1 -- Sustaining Medicare

Sustaining Medicare is a critical issue for women -- and the Report has done women an invaluable service by demonstrating that it is possible to sustain a public health care system based on the non-profit delivery of care services.

Because women have fewer economic resources than men, the rejection of user fees on the grounds that they increase disparity without improving care benefits women in particular.

The critique of public/private partnerships reveals the troubling consequences of such strategies, especially in the long term and especially for equitable access to care. Similarly, the evidence marshaled on the inefficiency and inequity resulting from for-profit health care is an essential ingredient in planning for a future we can all share. As the Report points out, the evidence suggests that non-profit delivery of nursing home and hospital care means better quality care (Romanow 2002:7). The mainly female patients obviously benefit from this better quality. Less obvious are the benefits the many women who work in the system enjoy from working conditions that allow them to deliver better quality care.

The emphasis on equity is particularly welcome. Defined in terms of "citizens getting the care they need" (Romanow 2002:14), an emphasis on equity could mean women's specific needs, and the needs of women in different locations, are taken into account. The attention paid to differences in access to care, in health outcomes, in quality, in physical location, and in treatment suggests this is the case. Women clearly have health needs that are different from those of men, although we are only beginning to realize the extent and range of these differences (Laurence and Weinhouse 1997). Less clear are the specific needs of women in different social and physical locations. Nevertheless we know enough to attend to these differences as well.

The discussion of the aging population appropriately stresses that it is not a catastrophe waiting to happen. Rather it is a contributing population with specific needs that should be met. This is particularly a women's issue because women live longer than men and are more likely than men to provide care to others well into their old age.

Yet the Report's entire discussion of equity, of aging, of disparities and of the determinants of health fails to consider gender divisions or gender consequences. This failure is difficult to understand, given that Health Canada recognizes gender as a determinant of health, and that the federal government requires a gendered analysis of such policy. It is difficult to understand given the evidence of women's unequal treatment in the health care system and of disparities among women. It is difficult to understand given that women constitute the majority of the old, and the overwhelming majority of the very old.

Being female makes a difference in health status, in involvement in the system, in the kind of care required and in options for purchasing care. This, in turn, makes a difference in how health care can be sustained. Gender is a central component in care planning, but is absent from the analysis presented in the Report.

Women sustain health care. They are the caregivers. They are also most of those who need care

and of those who take others for care. Planning for a sustainable health care system means planning with women in mind. The Report fails on this account. In spite of the evidence it presents, it also fails to recommend that for-profit delivery of care be prohibited. It thus fails to recommend that women be protected from inferior care or inferior caregiving conditions.

Chapter 2 -- Health Care, Citizenship and Federalism

Chapter 2 of the Report analyzes the relationship between Canadians and the federal, provincial and territorial governments. It emphasizes that Canadians value Medicare and expect their governments and other key actors to set aside differences and work together to develop a governance approach that will ensure the renewal of the Canadian health care system. Specifically, the Report calls for a "fundamentally new approach… not only to foster trust but also to resolve disputes and conflicts in a productive and transparent manner" (Romanow 2002: 47). For the Romanow Commission, effective governance is key to ensuring productive decision-making. As women told the Commission, it is also key to gender equality, because women are typically the first to suffer the consequences when intergovernmental relations strain or break down and social policies, including health care, are affected.

The Romanow Commission's expectation is that all levels of governments work together to respond to important social needs and priorities. Roles and responsibilities in this regard, the Report correctly notes, should reflect not only formal constitutional roles and efficiency but also take into account considerations of equity and justice.

The Report rightly points out that in recent years, a key obstacle to effective governance has been the actions of the federal government. On the one hand, the federal government has reduced its financial support for health care while on the other, it has continued to impose national standards. Indeed, in 1995, the federal government drastically cut social spending with the introduction of the Canada Health and Social Transfer (CHST). The CHST is block funding to provinces for all the areas previously covered by both the Canadian Assistance Plan (CAP) and the Established Programs Financing (EPF). As a result, provinces were forced to take a substantially larger financial responsibility for social policies, including health. Social programs and services were restructured with pronounced gendered impacts. Resultant cuts to social programs and the overall reduction of the public sector have been unevenly distributed among women, and in particular, young women, immigrant women, women of colour, and working-class women (Brodie et al. 1997). Poverty has increased and the conditions for healthy living diminished. Provinces have also deinstitutionalized and privatized parts of the health care system. As the majority of formal and unpaid caregivers and the greatest consumers of the health care system, Canadian women have been disproportionately affected by these changes.

Many provinces have taken the position that the federal government has reduced its political capacity to impose a national vision of health policy on the provinces. Without doubt the establishment of the CHST caused a significant deterioration in federal/provincial/territorial relations.

The Social Union Framework Agreement (SUFA) of 1999 is an attempt to improve social policy decision-making in Canada. SUFA sets out important principles that recognize the equality rights of Canadians and commits all levels of government to meet their needs. It attempts to re-establish respect for the principles of Medicare found in the *Canada Health Act*: comprehensiveness, universality, portability, public administration and accessibility. SUFA also prioritizes citizen engagement and Aboriginal rights, and commits governments to ensure

adequate, affordable stable and sustainable funding for social programs. However, SUFA's influence has been negligible. The continuing loss of national standards in social services and health entails a shifting away from universal publicly provided services of equal quality and is synonymous with a retreat from an equity agenda that would benefit women.

According to the Report, the changes required to improve the health care system are a Canadian Health Covenant; a Health Council of Canada; and modernization of the *Canada Health Act*, including stable and predictable federal funding through a New Canada Health Transfer and more immediately, targeted funding for health issues requiring urgent response. None of the specific recommendations for improving governance explicitly incorporate a gendered analysis with adequate attention to diversity.

Canadian Health Covenant

The Canadian Health Covenant is intended to be a new "social contract" endorsed by governments and based on Canadian values to guide the reform and modernization of the Canadian health care system. It is intended to clearly state Canadians' commitment to Medicare and the development of healthy public policies; set out objectives of the health care system for the public, for patients and for health care providers; inform, educate and support better decision-making in the health care system; and to serve as a common foundation for collaboration among governments, the public and health care providers and managers.

In the proposed template for the Covenant, the Report lists the importance of equity but does not elaborate on the fact that all populations are gendered, racialized and classed. This obscures the gendered dimensions of health and the distinct needs of women in relation to the health care system. And while the Report attempts to justify why the Covenant does not set out legal rights, as does for example, the Canadian Charter of Rights and Freedoms, the fact that the values and responsibilities that would be formalized in the Covenant could never be enforced means it would at best be symbolic. Similar limitations are true of SUFA, which is a non-constitutional agreement. As an administrative document, it has done little to transform intergovernmental relations and social policy. In comparison, women have had numerous successes in making claims for gender equity in government legislation under Section 15 of the Charter of Rights and Freedoms.

Health Council of Canada

The Report recommends a Health Council, built on the existing infrastructure of the Canadian Institute for Health Information (CIHI), for the purposes of facilitating cooperation and providing the best health outcomes in the world. Its responsibilities would be two-fold: to evaluate the health care system through the establishment of appropriate indicators, benchmarks and assessment tools; and to provide ongoing advice and coordination in transforming primary health care and the health workforce and to resolve disputes under a modernized *Canada Health Act*.

In terms of the first responsibility, there are limitations in traditional health care evaluation. Methodological approaches to evaluation research tend to focus on specific predefined outcomes (e.g., morbidity, mortality, compliance with health professional recommendations) rather than

processes. These methodological approaches tend to marginalize women's experiences and voices and overlook sex and gender and their implications for program and treatment outcomes. Health program evaluations need to take into account the generally greater needs and fewer resources of women, as well as the characteristics and treatment processes utilized in these programs. Further, an overriding construct in many health care evaluation models is quality of care. The manner in which we conceive of health and of our responsibility for it makes a fundamental difference to the concept of quality and the methods we use to assess quality of care (van Roosmalen et al. 1999). Clearly, gender perspectives influence concepts of quality.

The proposed structure of the Council does not call for proportional representation that would ensure gender equity or diversity in health care decision-making processes. There is no mention of the importance of citizen engagement through which women could voice their health care concerns. Another oversight is that the Report does not propose any dedicated Aboriginal representation on the Council. The Romanow Commission does not set out specific ways in which the Council could mediate disputes between the levels of government over the *Canada Health Act* nor does he address what kind of political power the Council would have to implement its decisions. As proposed, the Council would seem to fall short both in composition and power required for gender equity in health policy decision-making.

Modernizing the Canada Health Act

There is a proposal to confirm and expand existing principles of the *Act*. The principle of portability is strengthened to protect mobility between provinces and the principle of comprehensiveness is expanded to include medically necessary diagnostic services and targeted home care services (e.g., home mental health case management and intervention services, post-acute home care and rehabilitative care, and palliative care). The Report also proposes the addition of a new principle of accountability that would clarify the roles and responsibilities of governments, ensure stable and predictable funding, make health care spending transparent, and inform Canadians of the overall performance of the health care system. On one level, these changes to the *Act* appear promising for women. On another, any opening of the *Canada Health Act* raises the possibility of undermining those health care services that are already protected and are essential to women's health.

Eighty percent of all caregivers -- both informal and formal -- are women (Armstrong et al. 2002). Many caregivers also provide care for more than two generations simultaneously (e.g., providing care for elderly parents and providing care for their own immediate families). Because there is little recognition of the gender disparity in caring responsibilities within current home care policies, the Romanow recommendation to include certain aspects of home care under the *Canada Health Act* is promising. However, it does not address the needs of women who provide care at great personal, health and economic cost over long periods of time for chronically ill and disabled persons (Campbell et al. 1998).

In Chapter 11 the Report acknowledges the potential impact of trade agreements on Medicare if it were expanded to include home care. The Romanow Commission even goes so far as to call for foolproof mechanisms to protect Canada's health care system from free trade agreements. However, the Report provides no specific recommendations for how the proposed expansion of

the *Canada Health Act* in terms of home care can be protected from either a *North American Free Trade Agreement* (NAFTA) or a *General Agreement on Trade in Services* (GATS) challenge. Without such provisions, further privatization is a real possibility. In the process, women's caregiving responsibilities can only be expected to increase while state supports for care and remuneration for paid providers are likely to decrease.

Finally, the Report proposes a dedicated cash-only Canada Health Transfer to be built into the *Act*, one that is predictable and has a built-in escalator set for five-year periods. While the transfer is being established, it is also recommended that targeted funding be provided for a new Rural and Remote Access Fund, a new Diagnostic Services Fund, a Primary Health Care Transfer, a Home Care Transfer, and a Catastrophic Drug Transfer. The idea of a specific health transfer does address some important issues that emerged as a result of the block transfer CHST. For instance, there would be more transparency in regards to federal and provincial contributions to health care expenditures. However, there is nothing in this proposal that determines how the money may be used nor does it place any restrictions on for-profit delivery. Provinces may still have the power to decide whether the new health care money will be put into public or private services. Provinces dedicated to the privatization of health care, such as B.C., Alberta and Ontario, may therefore be able to agree in principle to the six pillars of the *Canada Health Act*, as they did in the Social Union, while in practice directing their spending to for-profit services. Such developments decrease access to essential health services for all women and in turn, undermine health and gender equity.

Chapter 3 -- Information, Evidence and Ideas

In this chapter, the Report explores how information and evidence, as key elements of Canada's innovation strategy, are integral to the reform of the health care system. Three areas are explored: the development of an electronic health record, improvements to the system of health technology assessment, and strengthening the research infrastructure in Canada, primarily through further investments in health research conducted through the Canadian Institutes of Health Research (CIHR) and through the establishment of new Centres for Health Innovation. Throughout this important chapter, there is no acknowledgment of the significance of gender either in the production or application of information and evidence.

The Electronic Health Record

The Commission proposes that the Canadian health care system move toward the integration of an electronic health record (EHR) for all Canadians. The EHR would include a record of all interactions with the health care system and would contain personal health information accessible both to individual patients and to all health care practitioners involved in patient care. Security measures would be taken to ensure that access to personal health information is restricted.

The central rationale for the EHR is three-fold. First, the current (paper) system of patient health information is unsystematic and not easily accessible by all of the health care providers offering care to individual Canadians. Second, the current system makes research on health system performance inefficient. Third, the EHR would significantly enhance the quality of health care by increasing health literacy and reducing duplication of records and medical errors.

There are a number of concerns about the EHR for women. First and foremost, there is no indication as to who would control the EHR. That is, who determines what information is recorded in or deleted from the EHR? This is a concern for all Canadians, but it can be of particular concern for women, given that research shows that women's and men's experiences in care can be vastly different. There is much evidence suggesting, for example, that women's medical complaints are more likely to be psychologized, and that women are more likely to be prescribed mood-altering drugs (Kaufert and Gilbert 1986; Pittman 1999). In short, women's bodies are more likely to come under medical surveillance (Nechas and Foley 1994; Rosser 1994; Treichler, Cartwright et al. 1998). Such surveillance becomes particularly problematic when health problems are associated with stigma, and when the security of the records cannot be guaranteed. Moreover, as is evident in other areas (notably the criminal justice system), sensitive personal information can and has been used against women.

There is an assumption that the development of the EHR will contribute to better health literacy among Canadians. As envisioned in the Report, Canadians would be provided with a secure online password for accessing their EHR. Then, through linkages to reliable health information on the worldwide web, Canadians would become better informed about their health and more empowered to make decisions about their health care. While in principle, this sounds like an innovative approach to increasing access to health information, it is proposed without regard for a gender analysis, or for that matter, a class or diversity analysis. The proposal presumes that the

worldwide web is the optimal way to provide Canadians with health information and that they can access this information through electronic means. Yet many Canadians, particularly the poor, do not have access to computers or to the worldwide web. Although women's use of information and communication technologies has increased in recent years, there are still many women in Canada who would not benefit from the Report's proposal for linking the EHR and electronic health information. Furthermore, the proposal sees the new information technologies as a preferred way for communicating health information. This ignores the important social functions of health care and the fact that many Canadians would prefer to have information communicated to them directly by health care providers in a language that is understandable and accessible to them, contextualized on the basis of their own life and health experiences.

Finally, the Report makes a strong case for the EHR as a vehicle for improving the quality of health care. This is a highly desirable aim, but it can and should occur regardless of whether the EHR is adopted. Women have raised concerns about the quality of health care for decades, yet in the current environment measures of quality of care are quite narrow, relying primarily on health system performance data (most commonly derived from administrative data alone). Shojania et al. note that health care report cards "often present a handful of relatively crude clinical outcomes (e.g., mortality and readmission rates) mixed with measures highlighting resource use" (Shojania et al. 2001: 82). This is only one aspect of quality health care, and in general the research conducted on this type of data (which is likely to continue with the EHR) lacks any kind of gendered analysis.

If the proposal for the EHR is adopted, it is imperative that measures be taken to address women's concerns about who adds or deletes information from the EHR, who has access to the EHR, and how women will access health information through the web and through direct service provision. It will also be important to ensure that initiatives designed to improve the quality of care not be limited to the EHR. Finally, given that the EHR is to be linked to the Health Council of Canada, women's perspectives on health care should be reflected in the composition of the Council, so that gender is considered in the determination of health needs and system performance.

Health Technology Assessment

Health technologies have dramatically transformed health care in the modern era. Because of medical advances and technologies, we now have a better understanding of some diseases and more effective ways of treating health problems. In an economy driven by what might be called "the innovation imperative," there are strong financial incentives to introduce new technologies. In such an environment, it is crucial that we ensure that technologies are effective and safe, and do not create or exacerbate social, ethical or legal problems. The Report proposes that under the auspices of the Health Council of Canada, actions be taken to "streamline technology assessment in Canada, increase the effectiveness, efficiency and scope of technology assessment, and enhance the use of this assessment in guiding decisions" (Romanow 2002: 83).

This appears to be is a worthwhile recommendation that will be of benefit to women. However, for more than three decades now, feminist researchers have been concerned with the application of technologies (Peters and Lawson 2000). The increasing integration of reproductive and

genetic information and technologies in health care has altered the practice of medicine, as well as how some individuals view their health and destiny, and this too has generated concern within the feminist community (Rapp 1987; Stanworth 1987; Royal Commission on New Reproductive Technologies 1993; Weir and Habib 1997). As Haran points out, "all women are implicated in the development of medical scientific practices that are directed towards women" (Haran 2002:85). And Armstrong and Armstrong remind us that women's social locations affect women's experiences of health and health care in diverse ways (2003). As many feminist analysts have suggested, there is not nearly enough attention to the impacts of these technologies, or to the ways in which these technologies may affect women and women's health (Rochon Ford 2000).

The Report is silent on the gendered nature of health technology, but by ensuring that the Health Council employs gender-sensitive approaches, the concerns of women may be taken into account in future health technology assessment.

Centres of Health Innovation

Consistent with the approach taken by the Royal Commission, the Report recommends building a solid evidence base to inform health care policy and practice. The primary vehicle through which this is to take place is the Canadian Institutes of Health Research (CIHR). The CIHR, established in 2000, provides funding to more than 6000 researchers through 13 institutes. The Report recommends that federal support for health research increase to $1 billion per year within the next few years. As well, the Report proposes that new Centres for Health Innovation be established within the CIHR, focusing on four key areas: rural and remote health, interprofessional collaboration and learning, health promotion, and pharmaceutical policy. It recommends that in the future the Centres for Health Innovation focus on areas such as patient safety, mental health, telehealth, genomics and proteomics, and chronic disease management. Finally, the Report suggests that health research in Canada become more global in its orientation.

Like the other sections of this chapter, there is no mention of gender or of women's health. Each of the areas identified for targeted research attention is gendered in nature. A further infusion of research dollars in the CIHR to study these areas should be of benefit to women. This will only happen if there is engagement with the Institute of Gender and Health and other women's health research centres to ensure that a gendered analysis of these issues is incorporated into the evidence base.

Chapter 4 -- Investing in Health Care Providers

Who Provides Care? A Critical Issue in Planning

Canada's health care providers are women-- and the fact that care work is women's work has profound consequences for how all care work is done. Nevertheless, the Report fails to acknowledge the gendered nature of care. Perhaps more significantly, it ignores the importance of this division of labour in addressing the future of Canada's health care workforce.

More than four out of five paid providers are women. They account for almost all of those who do the nursing work and for most of those who do the cooking, cleaning, laundry and feeding as well (Armstrong and Armstrong 2003; Canadian Institute for Health Information 2001). Men are the majority only in building maintenance and managerial work. Indeed 87% of health care managers are men while 80% of the providers are women (Canadian Institute of Health Information 2002: 28). Although most of the physicians are also male, women are rapidly moving into their ranks. The Report does acknowledge the impending gender shift, noting that "this has an impact in physician practice, with more female physicians choosing general and family practice compared to medical specialties" (Romanow 2002: 97). There is, however, no further discussion of the impact of this changing gender mix and the implications for care.

Women also account for the overwhelming majority of those who provide unpaid personal care in their homes and in the community as volunteers. Men help with the finances, with transporting food and patients, and with fundraising for care. And more men are providing support and direct care for their partners. However, it is mainly women who take on the primary responsibilities for unpaid care, even though most women now have employment in the paid labour force.

This is not simply about women doing what women have always done. Unpaid care work has increased enormously with the transfer not only of more care but of more complex care to the home. Indeed, more care is provided at home than in the formal care system, and more complex care is provided at home than in the past. Yet in the Report, the fundamental link between the shift from paid care provision in the public sector to unpaid care in the home is ignored -- along with the gendered nature of the work that makes the shift possible.

That women do most of the care work has critical consequences for human resource planning. Perhaps most significantly, the critical skills involved in the work are often invisible, and absent from the evidence used in planning for care. They are invisible in part because so many women do the work and because many of the skills were initially acquired by women teaching each other informally, often starting with the very young. It is assumed that women know how to care because they are women, and the acquired nature of the complex skills of care are not recognized.

Beginning with the nineteenth century efforts of Florence Nightingale, nurses have been struggling to have their skills become both more visible and more valued. Their close connection with doctors and technology, their increasing years of formal education, their research evidence on the importance of nursing care to health outcomes, their numbers and their collective efforts

to improve their conditions of work -- along with the shedding of many tasks traditionally associated with women -- have all contributed to their significant success.

Others working in paid care have had less success in making their skills visible and valued. Nursing aides, health care aides and home workers all provide critical aspects of care (Payne et al. 2000). The research on the determinants of health makes it clear that a clean environment and nutritious food are critical to everyone's health. But within health care, there are qualitatively different standards and needs. Health care by definition deals with particularly vulnerable populations. The nature, quality and availability of food are critical to those who are ill, disabled or recovering from care. Lack of appropriate nutrition can be fatal, and food provided as part of care is about much more than the risk of a poor cafeteria meal that the Report singles out. Unclean environments can spread life-threatening diseases that are impossible to see until their consequences are felt. As we know, Florence Nightingale established her reputation for reforming nursing practices that led to improvements in health outcomes primarily by cleaning up the environment for care.

The by-products of care are so dangerous that garbage must be handled in special ways. Moreover, those working in health care must learn to work around equipment that is not only fragile but life-supporting, creating the constant possibility for dangerous disruption. Health care laundry, like unclean operating rooms, presents risks to patients and providers alike. As a result, both the kinds of laundry produced in health care and the standards required for their processing are necessarily different from those in hotels. In all these areas then, it is not easy to assess quality or to compare it to similarly named work in the for-profit sector, as the Report suggests.

Those who do care work define themselves as health care workers both because they recognize the importance of their work to successful intervention and recovery, and because they know their work is different from that done outside health care. They also define themselves as health care workers because they do much more than clean, cook or do laundry. While they are doing their jobs, they interact with patients and even interpret for other providers, thus playing an even clearer health care role.

The Report perpetuates the undervaluing of this work, failing to recognize the critical role it plays in health and care. In arguing that "governments must draw a clear line between direct health services (such as hospital and medical care) and ancillary ones (such as food preparation or maintenance)" (Romanow 2002: xxi), the Report does not acknowledge the skilled nature of this women's work and the essential role it plays in intervention, in recovery and in maintaining health. The Report thus ignores the research on the social determinants of health and the specific needs of patients in care. In arguing that these services could be the domain of private providers (Romanow 2002: xxi), it offers no evidence that quality has been maintained by such enterprises or that conditions for women's work in these enterprises will allow them to provide quality services. Women who do this work in the for-profit sector are among the lowest paid, the least secure and the least likely to be trained for the work. In arguing that these services are "relatively easy to judge in terms of quality" (Romanow 2002: 6), the Report reinforces the invisibility of the skills involved in this women's work and denies the vulnerabilities of patients and the unique conditions in which the work is done. Governments should be promoting these as good jobs in

order to promote healthy public policy.

Hospitals are not hotels and patients are not clients.

This failure to recognize the full range of skills required in care spills over into the unpaid care women provide in the home and community (Payne et al. 2000). It is assumed that women know how to do the work and want to provide the care. Men are much more likely to get paid assistance in providing care and get training in how to do the work. But the skilled work required by both women and men providing unpaid care is underestimated. This is particularly the case with the skills involved in providing support, a clean, safe environment and appropriate food.

Assumptions about gender also have critical consequences for human resource planning. Like the invisibility of women's skills, the way women are perceived by others as well as how they perceive themselves has significant consequences for care work. Women's early learning, their educational programs and the assumptions about women's capacities built into the organization of work contribute both to making women feel responsible and to having others hold them responsible for care. For women, it is assumed that caring about someone means caring for them. This applies whether they are paid or not, formally trained or not, for the work involved. The high rates of injury and illness among paid health care providers that the Report notes can be understood only if we think in these terms.

But the assumptions cannot be understood solely in terms of the female dominance of the labour force or women's socialization. They must also be understood in terms of how health care work has been reorganized. Work in health care has become much more intense as for-profit practices for the organization of work are introduced into health care and funding is reduced. Patients have much shorter hospital stays and only those who are very ill or disabled are admitted to facilities. As a result, those cared for in the system have more complex needs and there are fewer people employed to provide the care. There is less time to care and less control over care for care providers. In spite of these changes, employers, patients and providers all expect the same level of care. Women have desperately sought to fill the gaps in care because they still feel responsible and are still held responsible for the same level of care. The high rates of satisfaction with care documented for the Commission demonstrate the results of their extra labour. But women have often maintained the quality of care at risk to their own health. And this is as true for the women who clean and feed the patients as it is for those who provide the most complicated nursing care. It is also true for the women providing unpaid care under what the Executive Summary describes as "tremendous strain."

That it is women who do the work helps to explain the morale and working condition problems identified in the Report (Romanow 2002: 113). It helps explain why the consequences of for-profit practices applied to care are only now becoming visible in higher rates of worker injury and illness (Armstrong and Jansen 2000). Unless the gendered nature of the work and the foundational assumptions are recognized, the "general feeling of dissatisfaction, exhaustion, and gloominess that too often prevail in the network's institutions" (Romanow 2002: 110) cannot be understood or adequately addressed. Unless the specificity of care work is recognized, care will not be there when we need it.

That women do the work is also a factor in explaining the high rates of casual, part-time and overtime work identified as a problem in the Report (Romanow 2002: 110). So is the adoption of for-profit practices. Women are much more likely than men to do part-time and casual work, especially those over age 25 (Marshall 2001). Women's domestic responsibilities make it more difficult to do full-time paid work. However, women are also much more likely to be offered part-time or casual employment.

It is often assumed that women want such employment. But the research indicates the overwhelming majority want and need full-time, permanent paid work. It indicates as well that secure employees with some control over their work are better employees in care work. In the for-profit sector, flexible workers who can be used when and where employers want are seen as the most efficient way to increase productivity. The increasing reliance on part-time and casual workers, supplemented by overtime work, is thus a strategy taken from that sector. The result, as the Report indicates, is a workforce "extremely dissatisfied with its work environment" (Romanow 2002: 110). It may also mean a disruption in the continuity of care. Yet the Report fails to link this development to either women's work or to for-profit strategies.

In failing to recognize the gendered nature of caring work, the Report fails to understand the factors that contribute to the declining quality of work life it identifies as a problem. The Report therefore promotes solutions that are likely to lead to deteriorating conditions for providers and for care. The call for "concerted, collaborative and decisive action" (Romanow 2002: 92) can only be effective if the entire range of providers is included in the call and if a recognition of women's places in care is a starting point for planning.

Nurses and Care

The Report does not mention that nurses are women, and that the overwhelming majority of nurses are women. It does pay attention to the declining morale among nurses. It recognizes their lack of control over decisions about their work and the deteriorating conditions of their work. Their situation is contrasted to that of physicians, who have considerable control over their practice. In making this contrast, however, and in making recommendations for change, there is no consideration of the role of gender in nurses' lack of control.

Women have less power than men throughout the system. So we should not be surprised if the predominantly female nurses have less power than the predominantly male doctors, even when their skills and experience overlap. Overcoming this imbalance, even in nurses' areas of expertise, requires recognition of the gender dimensions of power.

In short, nurses' position within the hierarchy of care has to be understood at least in part as a reflection of their gender. The same factors that have contributed to nurses having "little control over those changes" (Romanow 2002: 94) may mean that nurses will have little control over future decision-making unless the role of gender is understood and addressed. If nurses take on more of the physicians' work and more of the case management functions, as the Report suggests, they may get more responsibility without more control over their work unless gender assumptions and gender power differentials are challenged.

More flexible responsibilities and multidisciplinary approaches could also benefit nurses and patients. To do so means beginning by recognizing both the valuable skills nurses have and the way power imbalances reflect gender inequalities. Otherwise, the effort to re-balance the skill mix will simply mean nurses take over the work doctors no longer want and will pass on their unwanted tasks to other care providers, most of whom are women.

The Commission recognizes some of the risk when it says that "Each profession appears willing to take on more responsibilities, but unwilling to relinquish some duties to other professions" (Romanow 2002: 93), but once again, it fails to apply a gender lens. Such a lens would help reveal how gender contributes to this hierarchical structure and thus how a move towards collaborative teams based on recognition of skills can be achieved.

Similarly, the aging of the nursing profession identified as an issue in the Report should be understood as a new phenomenon, which reflects in part the changes in laws and practices that have allowed women to stay in the labour force. Until the 1960s, nurses had to leave their full-time jobs once they married. Canada has never had a nursing workforce dominated by middle-aged women as is now the case. This creates new issues for the organization of nurses' work and for the kind of work they can be expected to do, at the same time as the system benefits from a very experienced, skilled workforce. Many nurses are themselves being called upon to care for their elderly relatives, a pressure that is felt even more by women formally trained for the task. Although the Report considers nurses' retirement, it does not consider any of these other gender issues.

The Report points out that many nurses have sought work in the United States and will not return without guarantees for "the kinds of opportunities that are being offered south of the border" (Romanow 2002: 102). It thus usefully draws attention to the deteriorating conditions of work for women in care. However, the Report seems to be primarily concerned with the problems foreign-trained doctors face in having their skills recognized in Canada. It provides no discussion of the barriers female immigrants from the full range of health care fields face in having their credentials acknowledged here.

Getting Doctors

Access to physicians and surgeons is clearly an issue for women, given that they use the system more than men. Rural women in particular have had problems gaining access, so proposals to encourage rural resources are welcome. In short, the attention the Report pays to the training and distribution of doctors is beneficial for women.

However, there is no consideration of the consequences of the new gender mix noted in the Report. Given that women are more likely to go into family practice, what are the consequences for health planning and for the new teams proposed for primary care? What about their ability to relocate and fill the supply needs in rural areas?

Moreover, gender may play as important a role as the education, training and payment schemes identified in the Report as factors determining where doctors choose to practice, but gender is not considered in these terms. Nor is gender considered in terms of the recommendations for

more integrated education programs for doctors and other providers. These programs could benefit both patients and providers by developing an appreciation of the skills they can combine for care. However, without a gendered approach that acknowledges and addresses power differentials, these programs may merely ensure that the biomedical approach of doctors prevails.

Equally important, there is no discussion of how those currently employed can have their skills recognized and upgraded to fill the jobs created under new reforms. Many of the women currently working in the system have skills that could be the basis for addressing these gaps.

Managing Care

The Report points out that managers have a hard time managing under conditions of rapid change. The recommended stability in finances would obviously help managers plan more rationally and reduce the strain of constant change. It would do so not only for the managers but for the mainly women they manage.

The managerial practices that are the context for deteriorating conditions noted in the Report are not considered. In fact, there are no recommendations on how to better manage the health care workforce, even though the discussion of nurses clearly identifies problematic outcomes for workers that should be assessed in terms of managerial practices. Nor is there any consideration of the appropriateness of managerial practices taken from the for-profit sector. Given that the evidence on for-profit delivery demonstrates that it is inappropriate for care, it is important to consider the additional question of managerial strategies taken from that sector.

Just as the Report fails to mention that nurses are almost all women, it also fails to mention the male dominance of managerial jobs. In pointing out that there are fewer nursing administrators without noting that these managers were women (Romanow 2002: 94), it similarly misses the opportunity to provide a gendered analysis of managerial work. The shift away from nurse managers to senior managers means a shift away from women and often, from those with health care training. Does this shift play a role in the extreme dissatisfaction with the workplace environment identified in the Report?

Educating for Care

Education and training centred on practices that allow providers to "learn from, learn about and team with" each other is an essential ingredient in better care. It would allow women to share what they know while sharing in decision-making. It would thus go a long way towards addressing the invisibility of women's skills and their lack of control, if gender assumptions are recognized and addressed.

Patients and providers could benefit from education programs that ensure gender and diversity analysis as core competencies. A gendered analysis is required not only in planning for human resources, but in learning how to care. Gender makes a difference not only in relation to reproductive issues but to the full range of care needs. Thus a gendered analysis should be an integral component in these education programs.

A National Database

The proposed national database would provide an important resource for monitoring and planning in health care work. As the Report points out, national leadership is required in order to develop an effective human resource strategy. Such a database would be an essential ingredient in the strategy to be developed by the Health Council of Canada, a strategy that could address both cross-Canada distribution and shortages in health care workers. The database will be fundamentally flawed, however, if it does not track the full range of health care providers. The planning project itself will be fundamentally flawed if it does not recognize the critical role both gender and for-profit managerial practices play in creating the current conditions of care work.

Chapter 5 -- Primary Health Care and Prevention

The Report contends, as do many other reports on the status of health care in Canada, that primary health care in Canada requires a significant overhaul. As the major users of the health care system, as well as the majority of paid and unpaid caregivers, women have a significant interest in primary care reform. As the "health guardians" of the family (Heller 1986), women are responsible not only for their own health but for the health of others, across the spectrum of health care from health promotion to palliative care. The drive to bring care "closer to home" that is implied in most discussions of primary care reform, and which may include regionalization as well as community-based services, has mixed effects for women. These involve enhanced access to care but possibly increased responsibility for providing care -- particularly informal, unpaid care to family members. As, they raise issues of representation and standardization across different jurisdictions.

Women are most often the targets of health promotion and disease prevention efforts, both for themselves and others. Increased attention to these areas of health care, while welcome and important, nevertheless implies that women will be increasingly the target of information and education campaigns to reduce obesity, increase physical activity, reduce tobacco use and participate in immunization programs -- areas identified in the Report as priorities for action. To the extent that these campaigns individualize problems and blame women for their ill health and the health problems of family members, they compound women's sense of personal responsibility for health problems that are in fact largely beyond their control.

Canada currently operates a system of primary health care based upon physician services and hospitals, the two major components of the health care system funded by Medicare and enshrined in the *Canada Health Act*. In calling for primary health care reform, the Commissioner is joining the ranks of those who suggest that the current system of services is not meeting the needs of Canadians for timely, appropriate and affordable care.

The Commission's vision of primary health care is that it is an approach that combines medical, nursing and other health care services with disease prevention, health promotion and public health in a community-based organization appropriate for a given geographic or social community 24 hours a day, seven days a week. The promise of primary health care reform is more coordinated care, better quality of care and better use of resources. Obstacles to changes to the existing primary health care system include entrenched funding practices, existing professional scope of practice guidelines, inadequate support for disease prevention and health promotion in favour of curative and rehabilitative services, and the imbalance of services across the continuum of care, particularly home care.

The Romanow Commission proposes to address some of the challenges with primary health care reform through new resources in the form of the Primary Health Care Transfer, enhanced information through electronic patient records, a National Primary Health Care Summit, ongoing monitoring by the Canada Health Council through information from Canadian Institutes for Health Information (CIHI), and a focus on four areas: reducing tobacco use, reducing obesity, increasing physical activity and implementing a new national immunization strategy.

The Primary Health Care Transfer (PHCT) would consist of a federal government contribution of $1 billion a year for two years allocated on a per capita basis, matched by the provinces and territories, tied to primary health care. The building blocks of primary health care are identified (in order of priority) as continuity of care, better detection and action, better information on needs and outcomes, and new and stronger incentives. Funds transferred under the PHCT would be used to provide training and retraining for health care providers to work in primary health care, the implementation of new approaches to physician remuneration and the division of responsibilities among various health care providers, the expansion of health promotion and disease prevention programs and enhanced information collection to support the establishment of best practices in primary health care.

These directions for change are significant for women because women are the majority of the users of the health care system, both for themselves and on behalf of others. Thus women stand to gain the most from enhancements in access to primary care and greater continuity and coordination of health care and health services. It is therefore critical that women be involved in efforts to redesign the system so that it meets their needs as both paid and unpaid care providers and as users of the health care system. The challenge is to understand what coordination and continuity mean from the perspective of women themselves.

For example, the majority of women, including those of childbearing age, are employed. Regardless of their geographic location, health care services that are not available except during working hours or that do not provide child care services cannot be considered accessible to women. Further, women do not constitute a homogeneous group and services need to be sufficiently flexible to serve not only the majority of users but those who experience barriers to access arising from physical disability, age, class, sexual orientation, poverty, language or racism (Amaratunga 2002; Gilmour and Martin 2001).

The Report notes that there is little consensus on the best approach to primary health care and suggests that there will likely need to be various approaches. It recognizes the useful information being generated by demonstration projects funded under the Health Transition Fund and urges the funding of more such initiatives. While short on prescriptions at the level of the organization and funding of such new delivery mechanisms, the Report appears to favour salaried multidisciplinary teams of health care practitioners with a roster of patients providing care around the clock, seven days a week. From the perspective of women's health, planners should avoid a one-size-fits-all approach to health care reform and establish demonstration projects that operationalize women-centred care to develop approaches tailored to women's varied health care needs and preferences.

The Report mentions the numerous demonstration projects underway supported by the Health Transition Fund and recommends support to additional demonstration projects. This is a worthwhile recommendation as long as gender is considered when establishing and evaluating such initiatives.

Innovative services for women have been established at the James Bay Community Health Centre in Victoria, the Mid-Main Community Health Centre in Vancouver, the Abbotsford

Women's Health Clinic in the Fraser Valley of British Columbia, Toronto's Immigrant Women's Health Centre, Québec's CLSCs (local community service centres) and the longstanding Women's Health Clinic in Winnipeg. These centres each provide comprehensive primary health care services appropriate for women and offer them important new choices such as counselling, dental care, clinical pharmacy and health education.

Romanow completely ignores a critical example of innovative primary care services namely the provincial midwifery programs that are particularly relevant to women. The introduction of midwives into the health care team benefits both women and the health care system with respect to quality, effectiveness and efficiency (Moon et al. 1999). Midwives should technically be able to provide care for the vast majority of births that are defined as "normal," relieving obstetrician-gynecologists from this area of responsibility and reducing the overall medicalization of the birthing experience. In a related vein, the development of innovations such as freestanding birthing centres, separate from hospitals, to handle normal labour and deliveries would reduce the use of hospital maternity facilities and therefore reduce costs.

Primary care reform should therefore encompass efforts to expand the availability of midwifery services throughout the country so that this option for providing perinatal care is more widely available. This will entail increasing the training for midwives in Canada as there are currently only limited educational programs providing this training. Moreover, the introduction of midwifery should be monitored as it is implemented and research to support and assess midwifery practice must be undertaken (Kornelsen 2002).

The Report stresses the importance of increasing disease prevention efforts through individual lifestyle change and higher rates of immunization. While it acknowledges that factors beyond lifestyle and the health care system -- the social determinants of health -- make significant contributions to individual and population health, in the end the major recommendations for disease prevention are not to reduce poverty, improve the state of the environment or enhance social inclusion but rather to increase physical activity, reduce smoking and increase immunization.

The Report's emphasis on individual behaviours -- smoking, drinking, being sedentary-- while ignoring the structural context of behaviour is an approach that sets back the health promotion agenda nearly 30 years. As women have long made clear, it is imperative that campaigns undertaken on these issues be gender-sensitive and recognize the gendered implications of their messages. For example, if efforts to reduce obesity are not appropriately framed, they may exacerbate disordered eating among girls and young women rather than foster the increased physical activity that is the desired goal.

However, increased efforts to curb the rise in tobacco use among girls and young women are welcome. While overall smoking prevalence rates decreased over the decade from 1990 to 1999, smoking among teen girls is higher than among women overall and more teen girls (29%) than teen boys (28%) are smokers (age 15-19) (Health Canada 1999).

Research suggests there are gender differences with respect to nicotine dependence, smoking

cessation experiences and smoking prevention efforts (Colman 2000). For example, in a comprehensive best practices review of youth smoking cessation programs spearheaded by the Youth Tobacco Cessation Collaboration in 2000, there was no clear evidence of an effective approach to smoking cessation in youth. Only cognitive-behavioural approaches demonstrated some promise of efficacy. However, since the review did not include a gender-based analysis of the evidence, there is no way of ascertaining whether or not any smoking cessation approach in reducing smoking in girls is efficacious. Similar conclusions were reached in the U.S. Surgeon General's Report on Women and Smoking (2001).

Smoking and tobacco use are significant among Aboriginal girls and women, which suggests that current health promotion campaigns and policies are not meeting their particular needs (Greaves and Barr 2000).

In general, the Report's approach to health promotion and disease prevention, with its individualistic focus on health behaviour and its only minimal attention to the determinants of health ignores the literature that demonstrates the meaning and function in women's everyday lives of so-called "coping behaviours" such as smoking (Greaves 1996). The Report fails to consider the importance of community participation in designing health care and shaping the conditions that influence health.

The Report suggests that primary health care reform will provide incentives for both health care providers and individuals to increase efforts to reduce injuries and illness. These incentives appear to be largely financial, with health care providers and patients alike reaping the benefits of reduced expenditures on the treatment of health problems that are deemed largely preventable through lifestyle change: coronary heart disease, diabetes and some cancers. It is unclear how the new forms of health care practice will actually conduct these disease prevention and health promotion efforts, but presumably this will be accomplished through individual lifestyle assessments, health education campaigns, screening programs and behavioural modification.

Research has shown, however, that there are limited benefits to health education campaigns that fail to address the underlying social, economic and political conditions that shape so-called health behaviours. Similarly, heart disease may manifest differently in women and men and therefore may require different treatment strategies. Thus this approach to disease prevention and reduction of injuries is unlikely to be as effective at reducing health care costs as envisioned.

One of the limits of the approach to primary care in the Report is the lack of recognition of the interface between "care" and daily life. Women's role as health guardians for themselves and their families is not acknowledged, thus ignoring that the major targets of most disease prevention and health promotion initiatives are women (Heller 1986). Moreover, as women are the primary users of the health care system, any changes in the organization, delivery and funding of services is going to affect women more than men.

As the major users of the health care system, women stand to benefit from increased coordination and continuity within the system and from primary health care reform. However, it is important that models of primary health care that consider women's health care needs and the

factors that shape their use of health care services such as child care responsibilities and employment be factored into the design of such services (Barnett et al. 2002).

Women's roles as paid health care providers stand to change within the overall context of primary health care reform. Depending on the particular ways in which the scope of practice of the various health care providers are defined, this may mean increased professional opportunities for some workers, enhanced job satisfaction and improved working conditions. For other women, however, job reclassification may involve deskilling and a narrowing of the scope of practice, with concomitant reductions in job satisfaction and possibly reduced wages and lifelong earnings.

Finally, primary health care reform needs to consider women's roles as informal, unpaid health care providers. Effective primary health care requires that the other elements of the system that form the continuum of care, including disease prevention and health promotion, acute care, rehabilitation and palliative care are adequately resourced and easily accessible on a timely basis. If some of the mechanisms discussed elsewhere in the Report are implemented and home care is established as a key mechanism of the health care system, then women will be in a better position to benefit from changes in primary health care as well.

Chapter 6 -- Improving Access, Ensuring Quality

This chapter of the Report addresses several concerns, collected under the umbrella of better access to quality care: increasing access to diagnostic services, reducing waiting times and managing waiting lists more effectively, measuring and improving quality in the health care system, improving access for official language minorities, and addressing the diverse health needs of Canadians. The Report states that a variety of studies and opinion polls show that access to quality health care is one of the top concerns of Canadian citizens. But what do we mean by 'access' and 'quality'? How we define these concepts has important implications, particularly for women.

Access

The Report narrowly defines 'access' in terms of waiting time -- the amount of time one is on a waiting list before receiving a service. It suggests that there are more problems in waiting times for 'elective' services than for life-saving surgeries. From the Romanow Commission's perspective, the principal threat of long waiting times is that they create an opening for the privatization of health care: "Long waiting times are the main, and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public health care system" (Romanow 2002: 138). The Report recognizes that while shifting some services to for-profit facilities may improve waiting times for those who can afford to "jump the queue," this strategy may worsen the situation for other patients "because much-needed resources are diverted from the public health care system to private facilities" (Romanow 2002: 139).

This is a major concern for women, because women's health is put at risk when the public system is eroded. On average, women have lower incomes than men and are more likely to live in poverty especially older women (Lochhead and Scott 2000). Women are less likely to have supplementary health insurance coverage through their paid employment to defray the costs of services not covered by Medicare (Willson and Howard 2000). Consequently, women face greater financial barriers when health care (like diagnostic services or certain surgeries) is privatized. The Report rejects privatized health care delivery as the solution to long wait lists and waiting times. This is welcome news for women.

The Commission identifies improved access to advanced diagnostic technologies (such as MRIs and CT scanners) as the first priority for resolving the problem of waiting times. The Commission's proposed Diagnostic Services Fund would provide direct support to provinces and territories to purchase technology and hire and train the necessary staff and technicians to operate and maintain the equipment, as well as to interpret the results of the testing. It is foreseeable that this plan will benefit women who require these services, but this addresses only one of many determinants of health. Achieving and maintaining good health is not only about whether one can see a specialist or get an MRI. It is about access to other resources for health, such as adequate food and shelter, sufficient social and cultural supports, supportive work environments, and freedom from the harms associated with discrimination and inequality (Amaratunga 2000). When we consider how gender (which Health Canada has identified as a determinant of health) intersects with these concerns, it becomes clear that a broad and balanced definition of 'access' is particularly important to women.

This concern moved the participants of a recent national conference on the Social Determinants of Health Across the Lifespan to challenge the Commission to extend its response beyond biomedical care. It recommended that the $1.5 billion targeted for advanced diagnostic technologies must be matched by funding to address key social determinants of health such as safe affordable housing, early childhood development.[2]

Women have also challenged the assumption that new technology is necessarily beneficial. While the Report recognizes that we need more critical assessments of pharmaceuticals it does not recognize the need to assess the usefulness of new technologies such as MRIs and fetal monitors. Instead it focuses solely on gaining quicker access. Yet speedier access may result in iatrogenic effects.

Quality

A vision of quality also requires a gender lens. The Report recommends that the proposed Health Council of Canada "establish a national framework for measuring and assessing the quality of Canada's health care system, comparing the outcomes with other OECD countries, and reporting regularly to Canadians" (Romanow 2002: 150). It is hard to argue with a recommendation to improve quality. But how is that quality measured?

The Report defines quality in different ways for people in different locations. "For patients, high quality health care means that their needs and expectations are being met. For health care providers, quality health care means that their diagnoses are accurate, they are part of a well-functioning system, and the care they provide is appropriate and effective. For our society as a whole, it means that the overall health of Canadians improves" (Romanow 2002: 150).

Notwithstanding the broad definition of quality advanced by Commission, the Report proposes to measure quality in very narrow terms. For example, the recommendation to compare quality assessments with other Organization for Economic Cooperation and Development (OECD) countries would require Canada to adopt similar measurement practices, focusing on outcomes such as morbidity and mortality rates. These statistics tell us little about the social conditions of health, illness or care. They tell us nothing about the gendered experience of well-being or caregiving. Indeed our own review of the literature indicates that there are few quality indicators developed on the basis of women's experiences with care.[3]

The Commission's measurement plan focuses on biomedical aspects of care: utilization rates (how many treatments are done in a population) and outcomes (acceptable 'failure' rates). We

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[2]Further details on the conference (including the program and conference resources and recommendations) can be found at http://www.socialjustice.org/conference/english.htm.

[3] The National Coordinating Group on Health Care Reform and Women, with support from the Social Sciences and Humanities Research Council, is currently engaged in a national study entitled "What Does Quality Health Care Mean to Women?" Preliminary findings are anticipated by the end of 2003.

are told that "'we should judge the quality of professional work, delivery systems, organizations, and policies first and only by the cascade of effects back to the individual patient and to the relief of suffering, the reduction of disability, and the maintenance of health'" (Berwick 2002: 89 cited in Romanow 2002: 151). Not only does this perspective focus almost exclusively on outcomes (at the expense of health promotion and the processes of care), it ignores the conditions of work in which care is provided.

The working environment of health care providers is a critical determinant of health, both for the care providers and for the patients. High rates of precarious employment (e.g., contract work) and low rates of job satisfaction, combined with deteriorating working conditions put the health of care providers at risk (Armstrong et al. 2002). Moreover, if the health care system increasingly relies upon home care, how is quality and safety (for both patients and care providers) to be measured and assessed? What support is available to make home care environments safe for both patients and caregivers? For example, how much of home care work is done for minimum wages by immigrant and visible minority women who are isolated from colleagues and have limited control over their work environment? We know that the majority of paid and unpaid health care work is done by women; a gendered analysis of the conditions of that work must be included in any discussion of quality.

The Commission recommends that the Health Council of Canada should be responsible for developing a national quality performance assessment framework-- that is, it should develop a set of benchmarks or indicators against which the performance of Canada's health system will be measured. This framework would build on the work of the Performance Indicators Reporting Committee (which reports to the Deputy Ministers of Health) and the Canadian Institutes for Health Information (CIHI).

Many health determinants affect both women and men, but how those effects are expressed is influenced by the social relations of gender. There are differences in how women and men perceive health and illness, set health priorities and receive treatment (Abdool and Vissandjée 2001). Historically, however, health indicators have been developed without attention to the impact of gender. This practice continues despite explicit policy statements such as Health Canada's *Gender Based Analysis Policy* (2000) and *Women's Health Strategy* (1999). For example, although the core health indicators developed by CIHI disaggregate data by sex, they make no specific reference to gender -- the biological category "sex" is used as a proxy for the social category "gender." When we talk about gender as a determinant of health, we are referring to a complex set of social relations, not to a biological condition.

We need both biological and social indicators to form an accurate picture of the health of Canadians. Current health indicators do not adequately reflect women's specific health concerns (outside of reproductive health), nor their central place in the health care system as both recipients and providers of care. Furthermore, health indicators have traditionally been based on a disease model that does not attend to the social determinants of health. Not only does this model sideline the gendered experiences of health and illness, it does nothing to remedy the inaccurate perception that women's health is determined and dominated by the physiology (and potential pathology) of their reproductive systems (Abdool and Vissandjée 2001).

In 1999 the Advisory Committee on Women's Health Surveillance, chaired by the Hon. Monique Bégin, asserted that gender-sensitive research and policy-making tools are necessary to challenge entrenched, inaccurate approaches to women's health and to redress gender inequities in health. The identification of adequate and appropriate 'women's health indicators' that address determinants of health especially relevant to women, as well as acknowledge the inequities among women on the basis of socioeconomic status, "race," age, sexual orientation, (dis)ability, etc. is integral to adequate surveillance of and policy responses to the quality of Canada's health care system.

Chapter Six of the Report ends with a recommendation that "Governments, regional health authorities, and health care providers should continue their efforts to develop programs and services that recognize the different health care needs of men and women, visible minorities, people with disabilities, and new Canadians." In a document that spans over 350 pages, this recommendation garners only a page and a half of commentary. It refers to a potpourri of marginalized groups, and superficially reviews a handful of concerns that have been documented time and again in numerous other reports and in at least one Supreme Court decision. For example, in the Eldridge decision of 1997, the Supreme Court of Canada ordered the Government of British Columbia to pay for sign language interpreters when deaf people access health care services. The court ruled that the failure to provide sign language interpretation where it is needed for effective communication in the delivery of health care services violates the rights of deaf people. The court also made it clear that the government cannot escape its obligations even when it delegates the delivery of its most important programs, such as health care, to non-governmental bodies not usually subject to the Charter. Despite that ruling, most federal, provincial and territorial governments have failed to taken any steps to meet the obligations set out by the Supreme Court of Canada (Canadian Hearing Society 1999).

The Report offers no concrete and specific plan to address the systemic, complex issues that block marginalized individuals' and communities' access to care. Questions of accountability and enforcement must be answered. What role, if any, will the proposed Health Council play in ensuring that the persistent inequities women face are corrected? The Report declares: "Canadians have heard the promises before, then been disappointed by the lack of results. It is time to move beyond mere promises to clear deliverables. Canadians want action to improve quality and access in their health care system. They deserve nothing less" (Romanow 2002: 157). But in the absence of dedicated funding and an explicit action plan to meet the "diverse health needs of Canadians," what assurances do we have that the Romanow Commission's vague recommendations for an equitable system will not, once again, simply languish on the shelf?

Chapter 7 -- Rural and Remote Communities

Canadians living in rural, remote and northern communities are at a distinct disadvantage with respect to health and care. Typically they do not live as long as urban Canadians and they experience significantly higher levels of disease and disability. At the same time, they have limited access to both primary and tertiary care because many rural and remote communities have difficulty attracting and retaining health care providers, and because they cannot easily support specialized services. As the Report observes, "geography is a determinant of health" (Romanow 2002: 159).

While the Romanow Commission recognizes the shocking disparities in health and access to health care between rural and urban Canadians, the Report seems to ignore the fact that the majority of those using the health care system and providing paid and unpaid care outside of metropolitan and urban areas are women. It is not "people," as the report suggests, who must spend "days or weeks away from social support," it is mainly women who are separated from their families and friends when illness strikes and it is women who must travel great distances for essential reproductive health services (Romanow 2002: 162). In other words, the burden of getting and giving care falls most heavily upon the shoulders of women living in rural, remote and northern communities -- just as it does on women living in Canadian cities (Campbell et al. 1998; Skillen et al. 2001; Blakley and Jaffe 1999). Although the Report acknowledges that rural Canada is "not a single homogenous population," it fails to explore the gender dimensions of rural/urban inequities.

Given the Romanow Commission's commitment to publicly funded and publicly delivered health care, it is not surprising that he comments on the "added burden of paying for the high costs of travel... to access care" (Romanow 2002: 162) that is unique to Canadians living at a distance from primary and tertiary health care providers and facilities. What is surprising, however, is how little attention he pays to the ways in which privatizating trends in health care reform during the 1990s have contributed to poorer health and poorer health services in rural and remote communities. Regionalization of health care has resulted in hospital and hospital bed closures as well as the elimination of specific services in many smaller communities (Armstrong et al. 2002).

These kinds of reforms have had a dramatic impact on women. Between 1988 and 1995, for example, restructuring of health care in Nova Scotia resulted in the elimination of obstetrical and newborn services in 12 community hospitals (Clow 2002). As a result, women living in these communities are forced to travel to larger centres for regular prenatal care as well as hospital delivery. Moreover, women experiencing pregnancy complications may have to relocate to an urban centre for a month or more prior to delivery. Gendered analysis of the social and economic costs of health care would have helped to highlight the multiple causes of rural/urban inequities, a crucial first step in the formulation of viable and sustainable solutions.

Introducing the recommendations for rural and remote communities, the Romanow Commission asserts that "the place to start is with a vision where Canadians residing in rural and remote regions and communities are as healthy as people living in metropolitan and urban centres"

(Romanow 2002: 165). Unfortunately, the recommendations themselves are anything but visionary. They consist largely of the creation of a Rural and Remote Access Fund to expand the supply of health care providers -- specifically doctors and nurses -- in smaller communities and to expand the reach of telehealth services. Although the Report also recommends investing in "innovative ways of delivering health care services to smaller communities and to improve the health of those communities," it is silent on the possibilities of existing models of health care delivery, such as Québec's CLSCs (local community service centres) or mobile screening and treatment programmes. It also ignores the potential of other health care providers, such as nurse practitioners, to improve the health and care of Canadian women living in rural, remote and northern communities.

From the perspective of women's health, the recommendations range from disappointing to disturbing. One of the many reasons women utilize the health care system is pregnancy, but adequate prenatal care is frequently out of reach for many living in rural, remote and northern communities because they do not have a resident health care provider and cannot easily get to one. Midwifery would seem to offer a compelling alternative to the medical management of pregnancy and childbirth, yet the Report makes no mention of the advantages of training and licensing midwives for rural and remote practice. More worrisome is the recommendation that "training and support should be given to informal caregivers to support the role they play in rural settings" (Romanow 2002: 166). As we know, the overwhelming majority of "informal" caregivers are women. Is the Romanow Commission suggesting that we transform these women into paid caregivers or, as seems more likely, that we train them to provide a wider range of skilled services while continuing to withhold financial compensation?

In his address to the Canadian public on 28 November 2002, the Commissioner insisted that we need to move forward, to devise new ways of sustaining our health care system. Privately funded and privately delivered health care is no more workable now, he reminded viewers, than before the inception of Medicare. But neither his analysis nor his recommendations for improving the health of rural and remote communities are mindful of the needs of women. In this sense, his Report is also nothing new.

Chapter 8 -- Home Care: The Next Essential Service

Articulating the need for a "national platform for home care services" enshrined in a expanded *Canada Health Act* and an initial cash transfer from the federal government is an important step forward -- one that addresses critical problems in home care services. Yet while the Report notes that "caregiving is becoming an increasing burden on many in our society, especially women" (Romanow 2002: 184), some of the proposed remedies do not address needs or the differential roles for women and men. The steps recommended in the Report have the potential to create new inequities and may in fact exacerbate existing ones (Flood 1999).

The Report recommends the establishment of a Home Care Transfer to provide home care for post-acute home care, home mental health case management and palliative home care. The main concerns with the Report's recommendations regarding home care are the scope of the health conditions to be covered, the type and quality of the health care services provided and the mechanisms for supporting family members providing care.

Women are the majority of unpaid caregivers and the majority of care recipients and as such are greatly affected by home and community care policies and practices. Women and men also experience different socioeconomic contexts and gender role expectations, which result in women giving more hours of unpaid care than men, performing more demanding forms of caregiving than men, travelling farther and more often to provide unpaid care than men, and more often having responsibility for more than one care recipient than men. Women's participation in the paid labour force is also delayed or severely restricted because of their caregiving responsibilities (Morris 2002). A 2002 Decima poll found that the majority of family caregivers were providing care to family members who needed care long term -- that is, longer than six months -- and over 20% were providing care for more than 10 years. A Roeher Institute study of primary caregivers of children with disabilities, 96% of whom were women, spent three to four hours per day performing hands-on personal care (Roeher Institute 2000).

The Scope of the Health Conditions to be Covered

The Home Mental Health Case Management program outlined in the Report calls for an infusion of over $500 million to be directed to case management to support consistent medication use and behaviour management to reduce institutionalization or unmanageable behaviour. This implies a focus on treating those with schizophrenia, bi-polar disorders and dementia.

The recommendations focus on medication, but do not mention counselling, supportive housing or recreational and rehabilitation services as part of effective care. There is no analysis of the overuse of drugs in the treatment of mental illness and the problems associated with a drug-based approach. The proposed mean per diem cost is estimated at $35.15 and median cost of $18.16, which are inadequate if counselling and other services are to be included.

The analysis of needs is at best gender-blind. There is no mention of mental health conditions such as depression or associated conditions such as addictions, which require interventions other than consistent medication use. This is important because women are more frequently diagnosed with depressive conditions.

The Report effectively marginalizes mental health to the realm of home care. Although home care, especially for people with chronic and persistent mental health problems, is critically important in the Report, home care is discussed primarily as a way of managing people with "disruptive" behaviours and ensuring that they take their medications. The Report ignores the concerns that many of the individuals who use mental health care services have with respect to loss of individual autonomy and participation in decision-making. Case management and home intervention need to be accompanied by a wider range of both medical and non-medical supports. As the Canadian Mental Health Association (CMHA) pointed out in its brief to the Romanow Commission, people with mental illness are a disenfranchised group who depend on a strong public system and on broader non-medical supports like housing and access to adequate incomes in order to recover and maintain wellness (CMHA 2002).

The CMHA outlined the many ways in which people with mental health problems come into contact with the health system. Mental illnesses as a group, for example, represent the most frequent category of billings by general practitioners (Health Canada 2002). People with mental illness are some of the most frequent users of emergency services (Chan and Ovens 2002) and account for a large number of hospital stays (Health Canada, Statistics Canada and Canadian Institute for Health Information 1999; B.C. Ministry of Health Services 2000). In B.C. medications for mental illness represent a larger proportion (34%) than any other category of prescription medications (B.C. Ministry of Health Services 2000).

These statistics illustrate the ways in which people with mental illness use the health system in large numbers-- yet the Report ignores this fact. Mental health concerns must be integrated into the discussion of the health care system at every level and mental health providers and advocates must be seen as part of the health care system.

Women with mental illness often face specific forms of discrimination and tremendous barriers with respect to accessing care. This is especially true for women who live in poverty, women who are mothers, women who have experienced violence and women with concurrent substance use problems. This same group faces similar barriers in accessing the health care system for their physical health problems.

The services described as post-acute or "early discharge" support are narrow (e.g., case management, health professional services and medication management). They allow for 14 days after discharge from an acute setting or 28 days if rehabilitation is needed. This narrow definition suggests that there will be no assistance with daily living. The narrow time period will be a challenge for those who need a longer convalescence, for example the elderly or those living with chronic conditions. Also, it may signal a further increase in the shift of care from hospital to home with the accompanying impact on women as caregivers.

The Type and Quality of the Health Care Services Provided

Women experience more chronic health conditions and live longer than men, which means that they are more likely to need assistance with daily routines like bathing, homemaking and shopping. Women are the majority of paid home care providers, including those providing "ancillary services" such as cleaning, cooking, laundry and other essentials to supporting health

services in the home.

The Report calls for "medically necessary" home care services. This term is undefined and leaves room for interpretations that may result in inequitable treatment within and across jurisdictions. At the same time, the program areas of home care that laid out are detailed and prescriptive. Budget estimates are low and reinforce a biomedical orientation in home care. This relegates essential home support services such as cooking, cleaning and social supports to the margins by defining them as ancillary.

There remain other questions about "ancillary services": who will pay for them, what control or input care recipients will have, what the employment conditions for workers (the majority of whom are women) will be. For example, the examination of employment practices and quality of care in for-profit health services has demonstrated generally lower wages, lower benefit packages, if any, and little professional development (Ontario Health Coalition for the Hospital Employees Union 2002).

The Mechanisms for Supporting Family Members Providing Care
The Report's primary recommendation is for Human Resources Development Canada (HRDC) to develop proposals to provide direct support to unpaid caregivers who take time off work to provide care, using the Employment Insurance (EI) Program. This is an important step but it will not benefit all women equally.

Lack of pay equity, lower income levels for women, the fact that women are more likely to be employed part-time and more likely to reduce their paid employment due to family caretaking responsibilities-- all make it likely that women will receive lower benefits than men and be less likely to qualify for EI. Currently before the Supreme Court is the case of *Lesiuk v Canada*, in which the federal government is appealing a tribunal's finding that the EI rules were discriminatory against women.

Due to part-time work or work in jobs without extended benefits, women are more likely not to have extended benefit plans, making them less able to access services. Other mechanisms such as paid family leave provisions or pension plan payments for unpaid care providers are not recommended in the Report.

The Report is silent on other supports that informal caregivers have called for, such as respite services, training and family counselling services. The mention in the text of linking unpaid care providers to provincial information lines and 24-hour primary care support is visionary, but there is no specific recommendation to ensure that this will take place.

Chapter 9 -- Prescription Drugs[4]

In contrast to other subjects and issues addressed in the Report, the analysis of prescription drugs in Canada's health care system reflects some of the values and the vision evident in the Report's opening chapter. Chapter 9 comments on the wide disparities in coverage of drugs under provincial health plans, with some Canadians enjoying relatively generous benefits while others pay huge amounts annually in deductibles, co-payments, or out-of-pocket expenses for prescription medications. Women have a particular interest in prescription drug policy. Women are prescribed more drugs than men, especially psychotropic drugs and hormone therapies. Often drugs are prescribed inappropriately to women. Women are less likely than men to be included in trials to evaluate prescription drugs. Women are also less likely to be able to afford drugs, or to benefit from prescription drug plans.

"To a very large extent," the Report states, "people's income, the kind of job they have, and where they live determine what type of access they have to prescription drugs" (Romanow 2002: 194). As the Report points out, Atlantic Canadians, in particular, have significantly less coverage for prescription drugs than residents elsewhere in the country. The Report affirms that such inequities are unacceptable as well as inconsistent with the principles of the *Canada Health Act*.

The Report aims to gradually incorporate coverage for prescription drugs into a revised *Canada Health Act*, but in the meantime, the Romanow Commission proposes to "raise the floor for prescription drug coverage across Canada" (Romanow 2002: 190). The Report outlines five mechanisms to achieve greater equity, improved access to new medications and greater coverage of prescription drugs: the establishment of a National Drug Agency to evaluate new and existing medications for safety, efficacy, and cost; the development of a national formulary for prescription drugs to provide consistent coverage across the country; a thorough review of Canada's patent protection for pharmaceuticals with a view to improving access to cheaper generic drugs; the adoption of a medications management program linked to primary health care that would allow for monitoring of prescriptions drugs by a team of health care providers working with patients; and a substantial increase in federal contributions to provincial and territorial drug plans through a "Catastrophic Drug Transfer."

While this strategy has much to recommend it -- particularly the overarching goal of extending prescription drug coverage to all Canadians under the *Canada Health Act*-- it is also problematic from the perspective of women's health. The Catastrophic Drug Transfer is a case in point. According to the Report, the federal government would reimburse 50% of the costs incurred by provincial and territorial drug insurance plans above an annual threshold of $1,500 per person. In return, the provinces and territories "would be expected to expand access to prescription drugs

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[4]The Working Group on Women and Health Protection, a research alliance of the Centres of Excellence for Women's Health Program, has prepared a response to the Royal Commission's Final Report, with a particular emphasis on pharmaceuticals, their approval (including post-marketing surveillance) and their use. It is available online at http://www.whp-apsf.ca.

within their own drug insurance plans by reducing their deductibles or co-payments, or by extending coverage to people who are not now included under their plans" (Romanow 2002: 198). But guiding principles for the reform of provincial and territorial drug plans are absent from the Report, with the result that each jurisdiction would make its own decisions about how and to whom to extend coverage.

Each of these decisions would have profound implications for Canadian women because they are the majority of seniors -- who typically use more prescription drugs than other groups -- and because they are, on average, less able to afford prescription drugs than Canadian men. In Nova Scotia, for instance, all seniors in the pharmacare program are responsible for a co-payment on prescription drugs and single seniors -- again, most of whom are women -- with an income of more than $24,000 must also pay premiums of $215 per year. For those taking many prescription drugs, the costs can quickly soar beyond the "catastrophic level" and the federal transfer payments may or may not be used to alleviate their situation. Meanwhile, Nova Scotians on social assistance, many of whom are single women heading households, receive no aid with prescription drug costs. In Manitoba and Saskatchewan, coverage of prescription drugs has been more extensive, but in some cases, patients reported that they felt "subjected to second class treatment because their health cards identified them as social assistance recipients" (Willson and Howard 2000: 242).

Underlying this concern about the Catastrophic Drug Transfer is the question of who will make decisions about managing prescription drugs in this country. In the past, women have had "little say in how, where and when reform happens, in spite of the fact that they are the majority of both care recipients and care providers" (Armstrong and Armstrong 2003: 205). Moreover, as we know, women's issues have seldom figured prominently on reform agendas. Unless women and women's perspectives are integrated into the National Drug Agency proposed by the Romanow Commission, it is likely that policies formulated by that organization will continue to disadvantage many women in Canada. The furor over hormone replacement therapy -- not to mention major pharmaceutical disasters in the very recent past -- point up the dangers of relying exclusively on medical opinion for the evaluation of new drugs and monitoring of existing prescribing practices.

Finally, the chapter on prescription drugs, like other sections of the Report, raises privacy and security issues around the management of health information. The Romanow Commission recommends that a medication management program be established to link prescription drug use to primary health care through the mechanisms of electronic health records and electronic prescribing tools. Although this proposal is designed to foster appropriate, effective and economical use of prescription drugs, it has the potential to work against patients, particularly those who are vulnerable or marginalized. As pointed out earlier in this document, what information will appear in electronic records and who will decide what can be added or deleted? Who will have access to the information contained in the records? To whom will the records belong?

It is true that as the Report states, "prescription drugs play a growing and essential role in Canada's health care system and the health of Canadians" (Romanow 2002: 210). Prescription

drugs must be evaluated more carefully and made more widely available, otherwise the health of Canadians will suffer. But reforms to Medicare must respond to the needs and voices of those women giving and receiving care.

Chapter 10 -- A New Approach to Aboriginal Health

Chapter 10 of the Report acknowledges that "there are deep and continuing disparities between Aboriginal and non-Aboriginal Canadians both in terms of their health and in their ability to access health care services." It describes the poor health of Aboriginal Canadians as a "situation that is simply unacceptable and must be addressed" (Romanow 2002: 211). It does not, however, address the particular issues for Aboriginal women.

The Report calls for action to consolidate funding, create new models of health services, adapt health programs to the diverse cultural and socioeconomic circumstances of Aboriginal communities, and ensure that Aboriginal people have a voice in the design and delivery of health services. Although the Report recognizes the importance to health of social and economic conditions, the recommendations do not address social determinants of health such as employment, housing, income, education and a healthy environment. In this chapter, there are only two recommendations: to consolidate funding for Aboriginal health care services and to create new Aboriginal Health Partnerships, the forms of which would vary to reflect the needs of the communities involved.

It is true that consolidated funding could provide a firmer foundation to support the development and expansion of holistic, culturally appropriate health services and that the creation of Aboriginal Health Partnerships could provide opportunities for effective collaboration between Aboriginal communities and various levels of government. However, there are many more substantive details about directions for change in the work of the Royal Commission on Aboriginal Peoples (RCAP) and recent research on Aboriginal health.

Since this paper addresses the implications of the Commission's recommendations for the health of women, this section will focus on the changes needed to address the health needs of Aboriginal women. On this topic, the Report is virtually silent. While there is an acknowledgment of the cultural diversity among Aboriginal peoples, there is little recognition of the role that gender plays in shaping the health experiences of Aboriginal women and men.

In 1996, the RCAP reported that "Most Canadians enjoy adequate food and shelter, clean water, public safety, protection from abject poverty, access to responsive medical and social services, and the good health that results from these things. Aboriginal people are more likely to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death" (RCAP 1996: 1).

These health disparities can be more adequately understood, when sex, gender and culture are taken into account (McIntyre et al. 2001). Consider for example that the potential years of lost life (PYLL) is 2.5 times higher for Registered First Nations men than for other Manitoba men, but is three times higher for Registered First Nations women than for other Manitoba women. In 1997-98, only 26% of Registered First Nations women aged 50-69 received mammograms, compared with 56% of other Manitoba women in the same age category (Martens 2002). A

decade ago, the rate of cervical cancer for Registered First Nations women in Saskatchewan was six times that of other Saskatchewan women (Anderson 1994; Dion Stout 1996). And while rates of diabetes for Aboriginal Canadians are much higher than those of non-Aboriginals, within the Aboriginal population, women are at greater risk than men (Anderson 1994; Young 1988).

These data provide small glimpses into the gendered patterns of health disparities, but much more is needed to adequately identify the health needs of Aboriginal women and men. In particular, there are major gaps in sex-disaggregated data and in information related to the health of Inuit, Métis and urban Aboriginal communities.

The RCAP presented detailed information and offered recommendations to address many of the social, economic and environmental factors affecting the health of Aboriginal communities. In 1996, it proposed a health strategy based on "equitable access to health services and equitable outcomes in health status," "holistic approaches to treatment and preventive services," "Aboriginal control of services," and "diversity of approaches that respond to cultural priorities and community needs" (RCAP 1996: 4).

Many of the RCAP recommendations were reflected at the national forum on Aboriginal health issues, co-sponsored by the Commission on the Future of Health Care in Canada and the National Aboriginal Health Organization (NAHO) in June 2002. Participants at the forum emphasized the importance of greater Aboriginal control in the design and delivery of health programs and services. However, as Ambassador Mary Simon stated, "greater Aboriginal control of health services delivery should not mean less responsibility by the federal government" (NAHO 2002: 20). Whether the Romanow Commission recommendations provide a framework for greater Aboriginal control will depend upon the kinds of "partnerships" that emerge. Whether Aboriginal women will have a greater say in shaping the health care system remains to be seen.

RCAP proposed a system of Aboriginal healing centres delivering frontline services and healing lodges for residential treatment. Several participants in the June 2002 forum described culturally based holistic health services that combine western medicine, traditional healing and a range of programs to address community needs. The limits of the medical model call for a 200% solution-- that is, 100% of the best practices of Western medicine and 100% of the healing practices rooted in Aboriginal cultures and values (NAHO 2001). However, as Sharon Rudderham of the Eskasoni Health Centre in Nova Scotia pointed out at the forum, there is a need for policy changes and adequate long-term funding in order to maintain and expand the current innovative Aboriginal models of culturally based holistic health services.

The call for culturally based holistic health services is a response to the inability of mainstream health services to address the health needs of Aboriginal communities (Benoit and Carroll 2001). According to Dion Stout, "Aboriginal women often find health systems alien and confusing" and their "sense of unease is further exacerbated by care that is often insensitive to Aboriginal cultural values" (Anderson 1994 cited in Dion Stout 1996: 6).

A study with First Nations women in British Columbia found that their encounters with mainstream health services were often negative experiences in which the women felt dismissed,

their concerns were trivialized, or they encountered negative stereotypes. The lack of respect and cultural safety was further compounded by punitive practices and failures to recognize the social and economic realities of women's lives, including the legacy of residential school experiences and their lack of access to cars and phones (Browne, Fiske and Thomas 2000).

Several participants in the June 2002 forum on Aboriginal health emphasized the need for community participation in the identification of community needs and the design of holistic health and wellness programs. Ensuring that Aboriginal people have a voice in designing appropriate health services means including both women and men in the governance and decision-making processes. It also means taking gender into account when assessing community health needs and designing health programs.

Some Aboriginal health services and communities have begun to take gender into account and to examine the specific health needs of Aboriginal women. A study with Aboriginal women who were clients of the Vancouver Native Health Society and its sister organization, Sheway, found that "only by integrating what we have learned from Aboriginal women themselves into planning health service delivery can we hope to improve their health status" (Benoit and Carroll 2001: vi). In order for the Aboriginal Health Partnerships proposed by the Romanow Commission to be effective, they would need to listen to Aboriginal women and include this kind of gender-sensitive evaluation of health needs and health programs.

The Report recognizes the importance of ongoing Aboriginal input into the design and direction of health programs and services. In that context, it is worth noting the important roles played by Aboriginal women and Aboriginal women's organizations in identifying health needs and designing culturally relevant responses. Pauktuutit, for example, issued a report on Inuit women's health which highlighted three major concerns: violence, lack of access to health services and the devaluation of Inuit women's contributions to the health of their families and communities (2000). Québec Native Women has recently prepared a report on the health of Aboriginal women in Québec that addresses poverty, employment, housing and other social determinants of health, identifies the need to remove barriers to the development of holistic health services and calls for a recognition of Aboriginal women's leadership and participation in decision-making (Hannis 2001). Québec Native Women has also produced a report on the resilience, strength and successful steps toward healing of Aboriginal women who are survivors of residential schools (Québec Native Women 2001). Another example is the campaign by Inuit women "To Bring Birth Back to the Communities," that is, to have Inuit midwives and childbirth services available within their home communities.

The Aboriginal Nurses Association of Canada (ANAC) is another organization with a large proportion of women in its membership that has played an important role in identifying health needs and developing culturally appropriate services in Aboriginal communities. It is ironic that only a month after the publication of the Report, the ANAC had to suspend operations-- after 29 years of supporting Aboriginal nurses and promoting Aboriginal people's health -- because of lack of funding.

These organizations have an important role to play in the development of health services that are

more responsive to the needs of Aboriginal women, yet they are often limited by their lack of adequate resources. To be effective, the Commission's recommendations that advocate community participation in health planning must include women, and must provide the necessary resources to facilitate their participation.

Chapter 11 -- Health Care and Globalization

Globalization takes place in and is embedded within the context of already existing social inequalities, both nationally and internationally. This means that some of the key features of globalization as they relate to the health care system -- privatization, deregulation and increased mobility of labour and services -- have gender, racialized, ethnicity and class-differentiated effects with a specific impact on women.

This paper argues that health care is a women's issue because women are the majority of paid and unpaid primary care givers and the majority of the recipients of care, especially with respect to institutionalized care at the later end of the lifespan. The broad social determinants perspective on health advocated here reveals that social inequities, especially those related to poverty, unpaid work and employment have a disproportionate impact on women, especially elderly women, Aboriginal women, new immigrant women, single mothers and women with disabilities.

Since the signing of the *Canada and US Trade Agreement* (FTA) in 1989, the subsequent signing of the *North American Free Trade Agreement* (NAFTA) in 1994 and Canada's involvement as a founding member of the World Trade Organization in 1995, Canadian feminists have critically assessed trade agreements and documented how they affect women and men differently with a particular focus on the deleterious effects on women (e.g., Bakker 1996; Cohen 1987, 1997; Cohen and Pierson 1995; Cohen, Ritchie, Swenarchuk and Vosko 2002). Specifically, analysts have charged that agreements like the *NAFTA* are "inherently anti-public sector" because they either require the privatization of public services and/or require the reshaping of public programs to reflect commercial aims (Cohen 1995: 97). In the health care arena, it can be argued that Canada's involvement in free trade agreements will potentially affect women differently than men. This is especially true with respect to how these agreements support the privatization of certain parts of the health care sector (e.g., hospital support workers) and/or potentially prohibit the expansion of Medicare into areas like home care where women are the group primarily affected.

The Romanow Commission devotes one chapter to a discussion about globalization and health care. The Report makes strong statements about Canada protecting its health care system from the impact of free trade agreements and about Canada's international responsibility for promoting quality health care. It takes care to point out the ways in which globalization can increase inequities between countries of the North and countries of the South. For example, the Report calls the Canadian government's attempt to recruit foreign health professionals unethical because of the ways in which it drains professionals from poorer developing countries. Further, it calls on Canada to recognize that the global control of infectious diseases and the sharing of health knowledge require a commitment to understanding health as a human right and a commitment by the Canadian government to play a leadership role in promoting health in all societies. These goals should be applauded and reinforced. It is unfortunate, however, that the Report does not extend this analysis of social inequalities to the discussion of domestic health policy and trade agreements. Specifically, it misses the opportunity to reinforce points made earlier in the Report -- that gender is an important determinant of health and that women disproportionately bear the burden of care -- and to analyze them in the context of trade

agreements.

The Report does not adequately address the tensions the Canadian government is facing as a result of conflicting goals -- that is, to increase opportunities for commercialization of health care technology and to increase health service exports while at the same time maintaining a publicly funded health care system. For example, analysts suggest that the level of trade in health services is increasing as a result of health sectors being opened up in other countries and the development of new technologies that are enabling increased trade of health information and health professionals (e.g., telehealth) (Flood and Epps 2001). Canadian politicians have repeatedly assured the Canadian public that health care services are not on the trade-negotiating table, but they have contradicted this assertion by putting certain kinds of services on the table (e.g., in the *FTA* some rehabilitation services) and by exposing health insurance to market access rules in the *General Agreement on Trade in Services* (*GATS*).

There are four issues of particular relevance to women that flow from the Report:

- the degree to which Canada's health care services are currently protected under trade agreements,
- the likelihood that Canada will face a trade challenge in further expanding Medicare,
- the implications of allowing the further privatization of "ancillary" health services, and;
- transparency at the trade-negotiating table and citizen engagement.

Are Canada's Health Care Services Currently Protected under Trade Agreements?

Romanow demonstrates that he is aware of the debate with respect to the degree to which health care services are currently protected under free trade agreements. Specifically, he recognizes that the strength of current mechanisms protecting health care services in the *NAFTA* and the *GATS* rest on countries' shared understandings of what constitutes a public service. For example, Annex II in the *NAFTA* protects the health care sector from the full application of the *NAFTA* only to the extent that the services in question constitute "a social service that is established or maintained for a public purpose." Critics believe that this clause can be interpreted in ways that might leave services within the health care system that are funded and/or delivered through a mix of public/private partnerships open to foreign investment.

Indeed, evidence suggests that the US interpretation of this clause includes services that are publicly funded and privately delivered, while the Canadian government interprets the clause more broadly to include services where the "government intent" has been to offer the service for "public purpose" (Flood and Epps 2001). The implication of the Annex II reservation is that it potentially puts at risk services such as hospital support services, nursing and lab services that are beginning to be contracted out, but still have a significant amount of service in the public sector. It also exposes services not currently covered by the *Canada Health Act* to further privatization (e.g., home care and pharmaceuticals).

Under the scope and definitions of the *GATS* in Article I.3 (b) the governmental authority clause, WTO countries can exempt services "supplied in the exercise of governmental authority" but section (c) defines this as "any service which is supplied neither on a commercial basis, nor in

competition with one or more service suppliers"(*GATS* Annex 1B). As in the case of the *NAFTA*, this definition does not take into account Canada's mixed public/private system and thus could make it difficult for governments to argue for exclusions because most services have at least some private involvement.

The Report says "it is clear that Canada can and must take whatever steps are necessary to preserve the future of Canada's health care system and protect it from the potential impact of international trade agreements and laws." However, it does not heed the suggestions of legal and policy experts who point to the limitations of current country-specific reservations and ask that self-defining exemptions for health care services and Medicare be written into the body of trade agreements themselves (e.g., Canadian Centre for Policy Alternatives Consortium on Globalization and Health 2002).

What is the Likelihood that Canada Will Face a Trade Challenge in Further Expanding Medicare?

In the *GATS*, health insurance is included in a separate Annex on financial services and Canada has already committed health insurance to the rules of market access under this agreement. At the present time, foreign companies provide an estimated 10-30% of health insurance. Canadian life and health insurance companies operate in over 20 different countries (Finance Canada 2001). Through Canada's moves to export health goods and services it runs the risk of foreign markets demanding that Canada reciprocally open up its markets to foreign investment. Some analysts are concerned that if Canada wants to expand Medicare to include things like home care, pharmacare and disability insurance that foreign companies may charge that Canada is denying market access to their private insurers (Sinclair 2000; Sanger 2001).

So although extending Medicare is possible under current trade rules it could trigger either a *GATS* challenge (where compensation would be in trade concessions) or a *NAFTA* compensation claim. In the latter case, the *NAFTA*'s investment-state dispute settlement process allows US investors to directly sue the government for monetary damages where it is alleged that government measures expropriate foreign investments.

The Report discusses the degree to which Medicare is at risk under current trade agreements and makes the important suggestion that the Canadian government expand Medicare to include some aspects of home care and pharmacare now while the involvement of foreign interests is minimal. However, it makes no specific recommendation to exclude health insurance from the *GATS*, which is possible under Article XXI (Canadian Centre for Policy Alternatives Consortium on Globalization and Health 2002) and to take steps to protect Medicare under the *NAFTA*.

What are the Implications of Allowing the Further Privatization of "Ancillary" Health Services?

Although the Report discusses the problems with privatization of "direct" health care services (i.e., medical, diagnostic and surgical care) it distinguishes these from "ancillary" health care services (food preparation, cleaning and maintenance), which it says can be contracted out to for-profit corporations. The Report supports the further privatization of these services, despite evidence that such privatization in the US and Canadian context do not lower costs and may, in fact, lead to a degradation of service quality and labour standards (Cohen 2001).

In making a distinction between "direct" and "ancillary" health care services and arguing only for the protection of the former from privatization, the Report fails to recognize that the services in this so-called "ancillary" sector are essential determinants of the health of people in hospitals. Women, new immigrants and people from minority cultures perform the bulk of this labour. Following the release of the Report, some critics (e.g., the Canadian Labour Congress and the Canadian Health Coalition) have pointed to this and suggested that overlooking this sector will create a "new" underclass of health workers.

Transparency at the Trade-Negotiating Table and Citizen Engagement

The Report ignores altogether the fact that the people making decisions regarding trade agreements do so in almost complete secrecy and that those tasked with these decisions disproportionately represent commercial and business interests in the health care system (Canadian Centre for Policy Alternatives Consortium on Globalization and Health 2002). What is needed is complete transparency of trade negotiations, with the Canadian government publicly sharing its trade commitments and the schedules of the sectors it is trying to open up in other countries. Further, it is necessary that a wider range of expertise and opinion be present at trade-negotiating sessions, including people with expertise in health, education, social services and gender-based analyses. Both the pros and cons of trade liberalization must be fully understood before decisions are made. To this end, the Report rightly asserts that increasing economic interdependence should not compromise the ability of governments to make decisions about political, economic and social policies.

In the final analysis the Report should be recognized for its clear statements about protecting health care services from the full impact of trade agreements and for suggesting that Canada has an international leadership role to play with respect to ensuring that health care is valued as a human right. However, the Canadian government and health policy makers must heed the omissions outlined here and include a gender-based analysis in the discussion of trade agreements.

What is Missing in the Royal Commission's Final Report?

The Report quite clearly fails to provide a gendered analysis of health care. Planning that fails to take women into account is not only inadequate but also inequitable.

The Report fails to recommend the prohibition of for-profit delivery, even though it presents evidence demonstrating the problems with such delivery.

The Report fails entirely to consider long-term care, chronic care or care for people with disabilities.

The Report fails to discuss reproductive issues and access to these services.

The Report does not apply the lessons on international agreements set out in the final chapter to the other recommendations in the Report, even though they could have a profound impact on them.

What Does the Report Mean For Women?

We applaud the Romanow Commission for demonstrating the sustaining of Medicare. A publicly funded system delivered through non-profit services is crucial for all women in Canada. But like other reports on health care reform in the last decade, this Report fails to recognize the significant ways in which health care is an issue for women. Women are 80% of paid health care providers, a similar proportion of those providing unpaid personal care and a majority of those receiving care, especially among the elderly. The sustainability of the system is not just about finances, it is about women's work and women's care. Just as Canada should be a leader in seeing health as a human right, it should also be a leader in promoting gender equality in Canada and globally.

Investing in health care means investing in women. Unless this is understood, planning for care is bound to fail in its objectives.

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